FORM C-38

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
220 French Landing Dr.
Nashville, Tennessee 37243-1002

CASE MANAGER REGISTRATION

NAME: _____

TITLE: _____

CERTIFICATIONS:

	TYPE	CERTIFICATION NUMBER	DATE ISSUED	DATE EXPIRES
1.				
2.				
3.				

R.N. LICENSE NUMBER: _____ DATE OF EXPIRATION: _____

M.D. LICENSE NUMBER: _____ DATE OF EXPIRATION: _____

STATE ISSUING LICENSE: _____ TEMPORARY_____ PERMANEMT_____

IN ORDER TO PROCESS YOUR REGISTRATION, COPIES OF YOUR CURRENT R.N. OR M.D. LICENSE AND/OR CERTIFICATIONS MUST BE SUBMITTED WITH COMPLETED FORM.

COMPANY NAME: _____

COMPANY ADDRESS: _____

_____

_____

COMPANY TELEPHONE NUMBER: ( ) _____

YOUR OFFICE PHONE NUMBER: ( ) _____

FAX NUMBER: ( ) _____

EMAIL ADDRESS: _____

PLEASE LIST ANY PROVIDERS WITH WHOM YOU SELF CONTRACT:

_____

SIGNATURE: _____